21 July 2007
Chemist+Druggist
www.ukpharmacy.com

# The faces shaping your future?

## Industry demands national stop smoking service

- NPA/PSNC merger ruled out
- Get your GP on side with our new PBC column

# *Summer bites & stings? Tough TLC from down under.*

***Give your customers the kind of care they need.*** Care Stingose® Spray is the Aussie antidote for bites and stings which neutralises the venom itself. It relieves the pain and reduces the effects of bites and stings from wasps, bees, mosquitos, nettles, jellyfish and stinging plants - and it's effective for both adults and children. So if you're looking to apply some effective TLC this summer - recommend the antidote from down under.


*All the care you need.*

Always use normal first aid measures. Patients with a known or suspected alergy to insect bites or stings should seek medical advice.

**Presentation:** Pump spray for topical application. **Contains:** Aluminium Sulphate 20% w/v, Sodium Lauryl Diethoxysulphate, Fragrance SLS 9004 and Purified Water. **Indications:** Relieves pain and reduces the effects of stings and bites from insects, animals and plants. **Dosage and Administration:** Adults and Children: Spray immediately onto the affected skin. Re-spray if necessary. **Contraindications:** There are no contra-indications to Stingose. Some individuals may have limited skin reaction of short duration, but these are rare. **Warnings and Precautions:** Stingose should not be applied to the eyes. The skin must not be pre-treated with methyl spirits or alcohol, as this will reduce the activity of Stingose. **Pregnancy and Lactation:** No effects known. **Side Effects:** None known. **Legal Category:** GSL. **Licence Number:** PL 13227/0001 **Pack Size:** 25ml **Retail Price:** 25ml £3.99 inc VAT. **Trade Price per Single:** 25ml £1.88 exc VAT **Licence Holder:** Wellvalue Ltd. 1 Park Place, Canary Wharf, London, E14 4HJ. **Manufacturer and Distributor:** Thornton & Ross Ltd, Linthwaite, Huddersfield, HD7 5QH **Date of Preparation:** 12 03 07 Care+ and the lozenge device are trademarks of Thornton & Ross Ltd

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# New steering group snubs grass-roots pharmacists, say critics

Lack of grass-roots contractors on panel advising on new GPC claim industry representatives

Jennifer Richardson

**A group charged with advising** the government on the formation of a new professional regulator lacks a voice from grass-roots pharmacy, industry representatives warned.

The Professional Regulation and Leadership Oversight Group (PRLOG) – appointed by the Department of Health this week – is chaired by healthcare consultant Ken Jarrold and has 20 members, including Royal Pharmaceutical Society president Hemant Patel. However, the all-party pharmacy group expressed surprise at what it deemed inadequacies in the group's membership.

"We are concerned by the omission of the NPA [National Pharmacy Association] and PSNC [Pharmaceutical Services Negotiating Committee], as well as the lack of English grass-roots pharmacists represented in the group," the APPG said.

England's chief pharmaceutical officer, Keith Ridge, rejected the criticism as "unfair". "People were appointed on the basis of their skills and experience, not for representative roles," he said.

Speaking exclusively to C+D, APPG vice-chair Sandra Gidley MP said: "I could not see a coherent logic behind the collection of individuals in the group. If you want the profession to get behind a new regulator, you've got to engage at the very beginning. It's essential that the group finds a way to reach out to the wider membership." The inclusion of a pharmacy technician in PRLOG was "tokenistic", she added.

NPA chief executive Alison White backed the APPG's comments: "The omission of the NPA causes under-representation of community pharmacists," she said.

PSNC chief executive Sue Sharpe said she did not expect PSNC to be represented on PRLOG. "However, we are concerned at the very low level of representation of community pharmacists," she commented.

PRLOG will remain active until the establishment of the new regulator, planned for 2010, meeting four times a year. Details of its working methods are to be discussed at its first meeting, due next month.

**Chair of the Group**

- Mr Ken Jarrold, director of Dearden Consulting

**Members of the Group**

- Mr Raymond Anderson, PSNI president
- Ms Tracey Boyce, senior hospital pharmacist
- Ms Judith Cope, chief pharmacist, Great Ormond Street Hospital
- Professor Duncan Craig, University of East Anglia
- Mr Robert Darracott, chief executive of the CCA
- Ms Jennifer de Val, president of the BPSA
- Mr Stephen Griffin, County Durham and Darlington Foundation Trust
- Professor Mayur Lakhani, chairman of the Royal College of General Practitioners
- Mr Christopher Martin, independent community pharmacy owner
- Dr Norman Morrow, chief pharmaceutical officer, Northern Ireland
- Professor Peter Noyce, University of Manchester
- Mr Hemant Patel, president of the RPSGB
- Ms Fiona Price, pharmacy technician
- Dr Keith Ridge, chief pharmaceutical officer, England
- Mr Duncan Rudkin, chief executive of the General Dental Council
- Professor Michael Schofield, former RPSGB lay member
- Professor Bill Scott, chief pharmaceutical officer, Scotland
- Mr James Semple, TLC Pharmacy Group, Scotland
- Ms Rosie Varley, acting chairman of the Council for Healthcare Regulatory Excellence
- Ms Carwen Wynne-Howells, chief pharmaceutical adviser, Wales.

## Jarrold: 'I rely heavily on community pharmacy'

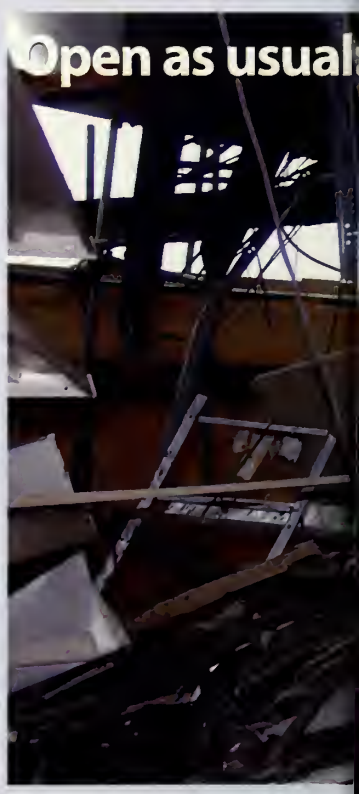
PRLOG chair Ken Jarrold has said that a key experience he brings to his new role is "as a member of a family which relies heavily on community pharmacy".

His pharmacist had looked after his family for 12 years, Mr Jarrold told C+D. "We immensely value his expertise, support and advice. It's important that I bring that experience to this role.

"I understand how important community pharmacists are to literally millions of people."

Mr Jarrold is a senior consultant at Dearden, a health and social care consultancy. He has 36 years experience in NHS management, including his role as human resources director in England.

His expertise in HR is also key to his position, as head of the advisory group for restructuring professional regulation and leadership in pharmacy, Mr Jarrold believes. "I've learnt a lot of hard lessons about how not to do reorganisations – and how to do it."




**When a fire engine smashed** through his pharmacy, bringing the building crashing down, Murtaza Master was determined not to let the damage prevent him serving his customers.

Staff at the Oldbury pharmacy had gone home when the truck veered off the road and smashed into the building. Mr Master said: "It hit two main pillars which were holding up the first floor so the beam collapsed, taking the whole first floor down with it."

The next morning, staff were running the dispensary in the car park. "Shutting is not an option,"

# Former NPA chief rules out PSNC merger

**Merger talks between the NPA** and PSNC are destined to fail, ex-NPA chief John D'Arcy has claimed.

Opposition from representatives on both sides is likely to sink moves to join the two bodies, Mr D'Arcy told C+D.

The former NPA chief executive who was involved in merger discussions before departing for Rowlands this May said: "It's like turkeys voting for Christmas. Why would politicians vote for something that could end up costing them their position on the board?"


Mr D'Arcy, who was at the helm of the NPA for 10 years, added: "It [the merger] has been knocking around for years and came up three times semi seriously during my time. It almost seems a bit of a red herring."

The comments come as a blow to merger discussions between the NPA and PSNC (C+D, April 7, p5).

Supporters of the move including PSNC's Sue Sharpe claim the organisations share "strong overlap" in their roles. However, Mr D'Arcy said: "There is overlap, but the extent is greatly exaggerated."

The PSNC and NPA refused to comment. **MG**

Should the NPA and PSNC merge?
**mgosney@cmpmedica.com**

# Industry calls for national smoking cessation service

**Industry chiefs are calling for** smoking cessation to be made an advanced service to improve the current "unpredictable and unstable" situation with enhanced services.

The move follows a C+D poll of PCTs that revealed pharmacy is the first choice provider for stop smoking schemes. However, this is not reflected in the reported extent of commissioning.

Less than half of pharmacies are commissioned to supply NRT on vouchers and less than 40 per cent commissioned to provide the level 2 advisory service, the poll carried out by Webstar Health found.

Budgets for smoking cessation are unchanged in around half the 47 PCTs questioned and in 5 per cent funding had actually fallen at a time when demand for the service is likely to be increasing.

Sue Sharpe, chief executive at contract negotiating body PSNC said: "This trend [growth in pharmacy smoking cessation services] should lead to the provision of a standardised national stop smoking service as a new advanced service within the contract."

The CCA also backed calls for smoking cessation to move into the advanced tier of the pharmacy contract.

Paul Gimson, lead for long-term conditions at the Royal Pharmaceutical Society, added: "There is good evidence for the role that pharmacy can play and most people seem to agree that pharmacy can and should contribute – yet services are not being commissioned to reflect this view."

But Umesh Patel, head of medicines management at Ashton, Leigh and Wigan PCT, said making smoking cessation an advanced service would not guarantee some cash-strapped PCTs.

"It would still be vulnerable, if there's no money there's no money." **EW**

See the full smoking survey results on p12

# pharmacy hit by fire engine

Photos: Mike Gutteridge

Mr Master said. "Some people would really panic if they couldn't get what we provide."

Mr Master is unable to maintain other services but is determined that the dispensary keeps running. "We're having supplies delivered as regularly as usual and we're dispensing as normally as we can," he says. "We've got great staff who have all rallied round."

Customers are grateful for the pharmacy's efforts. "We've had so much support from the patients. Quite a few have said the pharmacy is part of the area. It's really touching," Mr Master said. **JR**

## News in brief

### New Dawn for pharmacy

Dawn Primarolo has been named as pharmacy minister. Ms Primarolo takes on the position from Lord Hunt as part of her role as minister of state for public health.

### Contract funding delay

PSNC has said it plans to have the 2007/08 contract funding package finalised by the end of August. Talks have been delayed by Lord Hunt's departure as pharmacy minister, PSNC said. The organisation also reported that the number of medicines use reviews carried out had increased to 78,000 in March 2007.

### Quota row

Pfizer is imposing quotas on Lipitor, Viagra and Genotropin, PSNC reported at its committee meeting last week. However, Pfizer said it was "dedicated " to meeting demand for its products. "It is critical for Pfizer that every UK pharmacy is able to buy sufficient supplies of our medicines," a spokesman said.

### £1,000 safety award

The 2007 Almus Patient Safety Award has invited entries from pharmacists, technicians and pharmacy teams who can demonstrate best practice in patient safety. The winner will receive a £1,000 prize. For more information, see the entry form with this issue of C+D or www.dotpharmacy.com/PSA

### NCSO update

The DH and the National Assembly for Wales have agreed to allow NCSO endorsements for the following items for July 2007:

- Diamorphine injection ampoules 5mg
- Diamorphine injection ampoules 100mg
- Diamorphine injection ampoules 500mg
- Mefenamic Acid 250mg capsules
- Nitrofurantoin 50mg tablets.

### Over The Counter

Don't forget to give this month's copy of OTC magazine to your pharmacy staff. Each of the articles on sports injuries, fertility test kits and foot conditions has a quiz and the chance to win gift vouchers.

PBC week
September 24-28

Submitting a formal, written service proposal to practice-based commissioners is not the first step to pitching to supply services under practice-based commissioning (PBC). In regular columns over the coming weeks, we'll cover the key steps to engaging with PBC and securing business through this high profile commissioning route.

## A step-by-step guide to PBC

**STEP 1**

### Improve your relationship with neighbouring GPs

**Stephen Fishwick, NPA**

Positive local relationships are key to seamless patient care. They are also vital to generating new business via practice-based commissioning.

If there is not already a constructive, ongoing dialogue with nearby GP practice/s, seek to foster one around routine interfaces and how to manage these efficiently. Perhaps:

- In the case of prescription queries during surgery hours, how to obtain prompt clarification from the practice with minimum disruption at both ends.
- How to ensure GPs receive all relevant information about patients on their lists while avoiding information overload – MURs are a case in point.
- Ensure the practice is aware of the full range of services your pharmacy offers their patients.

Once a baseline of understanding, plus effective routine communication, is established, continue to build bonds of trust and mutual respect, including with practice staff; the practice manager will probably be drafting PBC plans for the practice.

Meanwhile, encourage your LPC to intensify dialogue with relevant PCT/PBC professional leads and the local medical committee. The LPC should be explaining the pharmacy contractual framework and seeding ideas about how community pharmacy can improve patient care and achieve value for money in the local health economy.

Next time: generating ideas for a PBC service

# Industry unites to save pseudoephedrine sales

Stakeholders take case to the Commission on Human Medicines

**Emma Wilkinson**

Stop the Switch. Pictured from the left are: Carlton Lawson, Johnson & Johnson; Colette McCreedy, NPA; Graham Phillips, RPSGB; Helen Darracott, PAGB; Sheila Kelly, PAGB; David Pruce, RPSGB; Rob Darracott, CCA; Michelle Styles, NPA; and Sadia Khan, RPSGB

**Pharmaceutical bodies have given** evidence to the Commission on Human Medicines this week as part of the profession's fight to keep on selling pseudoephedrine and ephedrine-based medicines.

The CHM will brief MPs on whether to go ahead with proposals to make affected products prescription-only. But it is unclear whether this will happen before parliament breaks up for summer recess.

Feedback from the bodies, which included the NPA and the Royal Pharmaceutical Society, suggested the meeting had been a useful tool in lobbying for pharmacy's ability to police sales.

The CHM triggered moves to make pseudoephedrine and ephedrine prescription-only after receiving police advice that criminals were buying packs of drugs from pharmacies to manufacture the class A drug crystal meth.

However, stakeholders have put the government under heavy pressure to abandon reclassification after highlighting industry intiatives to tighten control over sales.

The NPA reiterated this week that it was vital pharmacists immediately instigate a policy to limit packs to one per person to prove the system could work, especially as a decision may not be made until September.

Symbol group Numark has also issued an SOP to member pharmacies to help staff appreciate the importance of controlling sales of PSE products, after requests for guidance.

Stand up for your hero: William Brockedon – inventor of the tablet press – has been nominated by Ann Lewis, RPSGB secretary and registrar, for an award to celebrate unsung medical heroes. Members of the public can nominate their favourite understated scientist or even local pharmacist as part of the competition run by the book chain Blackwell. The awards are supported by medical charity The Wellcome Trust and are on display at the Blackwell's medical store opposite London Euston station. www.blackwell.co.uk/heroes

# Struck off for faking papers

**A Walsall pharmacist has been** struck off for forging documents in a bid to extend his business.

Mazair Iqbal of Pargeter Street, Walsall, faked a Land Registry paper as he attempted to gain approval for a pharmacy at Pensnett, Dudley, an RPSGB disciplinary hearing heard.

Committee chairman Judge Mota Singh QC said: "His dishonesty was at the most serious end of the spectrum, his conduct was deliberate and premeditated with the intention to deceive."

Mr Iqbal, who was owner of Advance Pharmacies in Dudley, had acted "totally out of character", Judge Singh added.

Mr Iqbal said he had been "upset and bitter" about losing a contract he had been working on for over a year. He said: "I still feel bad about it – it was a stupid action. If I could go back and change it, I would."

Mr Iqbal was fined £6,000 and ordered to pay £400 costs by Dudley Magistrates Court after admitting two offences under the Forgery and Counterfeiting Act 1981 on December 9, 2004.

Mr Iqbal has three months to appeal against the decision.

Meanwhile, a pharmacist from Leeds struck off in 2002 for making £9,000 in false claims has been restored to the professional register this week. Judge Singh told Bhupinder Singh Bharj, formerly of 227 Dewsbury Road, Leeds: "You have been given another chance – make the most of it."

Fellow Leeds pharmacist Yui Pui Tsang was also restored to practice after being struck off in December 2002 for obtaining NHS money by deception. Judge Singh said Mr Tsang, 45, and now of Stoneley Lane, was a "proper case for restoration". **UKL**

NEW IN SMOKING CESSATION

# THE POWER TO HELP THEM QUIT.[1-3]

- **A new class of oral prescription therapy with a unique dual action:**[1,2,4]
  - **Partial agonist** action: Reduces craving and withdrawal symptoms†
  - **Antagonist** action: Reduces the satisfaction associated with smoking†
- **Significantly higher quit rate vs. bupropion or placebo at 12 weeks**[1,2,5]
- **Favourable safety and tolerability profile in approximately 4,000 treated smokers**[6]

†Based on the Minnesota Nicotine Withdrawal Scale (MNWS)

**CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION - UK.** Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment*: No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events*: Dosing may be reduced to 1 mg once daily. *Severe renal impairment*: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease*: Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Effect of smoking cessation: Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side effects were increased appetite, somnolence, dizziness, dysgeusis, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence dry mouth and fatigue. See SmPC for less commonly reported side effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1 mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1 mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 09/2006

**Adverse events should be reported to Pfizer Medical Information on 01304 616161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk**

**References: 1.** Gonzales D *et al.* JAMA 2006; 296:47-55. **2.** Jorenby DE *et al.* JAMA 2006; 296:56-63. **3.** Tonstad S *et al.* JAMA 2006; 296:64-71. **4.** Coe JW. J Med Chem 2005; 48:3474-3477. **5.** Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. **6.** CHAMPIX Summary of Product Characteristics.

CHA055a Date of preparation: Nov 2006

Pfizer

New oral prescription medicine

CHAMPIX

varenicline tartrate

## News in brief

### New Code of Ethics

The new Code of Ethics for pharmacists and pharmacy technicians will take effect from August 1.

A preview of the new code can be accessed on www.rpsgb.org via the Consultations page.

### Unseasonal sales

Sales of cough and cold remedies are up 247 per cent on this time last year, according to Boots. But the unseasonally wet weather has also brought a dip in hayfever remedy sales, said the retailer.

### Hypertension guide

Numark has relaunched a hypertension booklet to help its members identify and assist patients with high blood pressure. Numark members can obtain a copy for £12.50 (including postage) from central office 01827 841200.

### Nucare pre-reg course

Nucare has launched a pre-registration training programme for 2007-08. It is free to members and starts with a tutor training day on July 24 in Milton Keynes. www.nucare.co.uk

# Profession not over-represented, say bodies

## Organisations hit back at criticism in APPG report

**Max Gosney**

**Pharmacy leaders have refuted** MPs' claims that the profession is over-represented.

Organisations defended their record of collaborating on universal industry concerns after a government report claimed the profession suffered from not having "a single strong voice".

The large number of representative groups reflected the diverse needs of pharmacists, said the CCA. "Different groups will sometimes view the world differently; and indeed, bring different perspectives to the table that inform policy development," the organisation said in its response to last month's all-party pharmacy group report. However, shared working should be encouraged "wherever possible", the CCA told MPs.

The report into the future of pharmacy risked confusing quantity with quality of representation, said NPA chairman Dilip Joshi. "I don't think that one voice means a strong voice. We're always looking at a closer relationship with other bodies."

Pharmacy bodies had partnered effectively when it mattered most, added John D'Arcy, Rowland's commercial director and former NPA chief executive. "Pharmacy collaborated on the OFT inquiry and most recently pseudoephedrine. We've got to recognise that there are differences of views."

However, the abundance of stakeholder groups had slowed the rollout of new services, said Steve Dunn, group managing director at AAH Pharmaceuticals. "That [case for delivering new services] is not helped by the alphabet soup of representative bodies when we need one clear voice."


**Loud and clear: large numbers of groups reflect diverse professional needs**

# Your views

# Proud to be English

## England is not Britain, and, as Jonathan Buisson suggests, it's OK to be different

**From the title of the all-party** pharmacy group's excellent new report, The future of pharmacy, you'd think it applies to the whole of pharmacy. But even a quick read shows that it's really about community pharmacy in England (plus a pinch of Wales and hospital pharmacy).

What's wrong with saying "England"? The RPSGB's English Pharmacy Board (EPB) was formed to recognise the fact that England is different from the other home countries. We will be looking at the APPG report in detail at our meeting this month.

For pharmacy, differences in health policies across the UK are showing up in things like pharmacists with a special interest (PhwSI) – currently an England-only policy. This policy reflects what happens to many pharmacists: over time they take on and develop a special interest in a particular disease or patient group for a variety of reasons.

Eventually they become recognised informally by their peers for their expertise and advice in a particular area. The PhwSI policy seeks to formalise this and to allow services to be developed around this. The EPB wants to look at practical ways in which pharmacists can be supported and PCTs encouraged to develop PhwSIs.

The APPG report highlights two main issues with pharmacy in England. The first is integration into the NHS. The APPG says that there has been "slow and inconsistent progress in pharmacy service development". The EPB shares this concern. We want to see successful services introduced widely with support to do so.

The second is collaboration between pharmacists, GPs and PCTs. This is a challenge not only to PCTs and GPs but also to us as pharmacists. We need to engage with them if we are to see more services developed. However, we also need them to engage with us. Both sides must be prepared to talk and to take action.

The APPG proposes a wider range of national advanced services. If these are adopted then the EPB would want to see how they can be supported and how appropriate standards can be set.

Underlying all of this is another taboo topic: money. The APPG hints at the need for an "increase in the nationally agreed funding available", and talks about a QOF points system for pharmacy. It is around this subject that the future of pharmacy in England will be decided.

England is not Britain or the UK and pharmacists should be proud to say that that is where they work, providing properly funded services that patients want and appreciate.

**Jonathan Buisson is an English Pharmacy Board member**

# New Name, Same Reliable Quality.

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NEW NAME
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**Available from your usual wholesaler as normal.**


**Barrier**

| | Size | PIP Code |
|---|---|---|
| pre-cut dressing | 2.4 cm | 048-6449 |
| | 2.2 x 6.3 cm | 033-1686 |
| | 2.2 x 7.2 cm | 033-1694 |
| | 2.2 x 3.8 cm | 033-1678 |
| | 3.8 x 6.3 cm | 033-1710 |
| | 5.0 x 7.2 cm | 033-1728 |

**Barrier**

| | Size | PIP Code |
|---|---|---|
| fingertip dressing packs | 4.4 x 5.0 cm | 029-7697 |
| | Wallet packs | 209-5222 |
| | No.2 assorted | 033-1967 |

**Detectable**

| | Size | PIP Code |
|---|---|---|
| pre-cut dressing strips | 2.2 x 7.2 cm | 033-1579 |
| | 3.8 x 3.8 cm | 033-1587 |
| | 5.0 x 7.2 cm | 033-1595 |
| fingertip dressing packs | 4.4 x 5.0 cm | 049-9897 |
| | Assorted | 004-9320 |
| | Wallet packs | 095-3166 |

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# Your letters

## The RPSGB and the Carter Working Party

> The Society published these snapshots of our early thinking in the desire to be as open as possible with the membership and other stakeholders

**Your article last week about the** Society's evidence to the Carter Working Party entitled 'Society ready for legal challenge over Royal College' (C+D, July 14, 2007) is significantly misleading.

The DH asked us to identify the risks associated with the transition to a general pharmaceutical council and a professional body. Our response duly included risk assessments of the various conceivable routes to the new bodies. As our summaries make clear, we explored the worst case scenario as well as the best – as is standard practice in a risk assessment. When we submitted the originals to the DH we made it clear that this approach was intended to be helpful.

Nowhere in the documents does it say that the Society is "ready for a legal battle", or that "the government faces a minimum £13 million pound bill". In our analysis of possible risks to be faced should the government choose to adopt the "high-friction" route of dissolving the Society and initiating a new professional leadership body, we did indeed say that this would be seen as heavy-handed, could be lengthy and could be subject to opposition and legal challenge, although we did not say that such legal challenge, assuming it ever arose, would come from the Society.

C+D seems to have translated our identification of the risks that need to be managed into predictions of the future. The Society published these snapshots of our early thinking in the desire to be as open as possible with the membership and other stakeholders.

Misleading and alarmist interpretations will only serve to discourage all parties from being open and cannot help to achieve a good outcome for pharmacy and the public.

**Hemant Patel, RPSGB president**

## Concern over IT report

**The chapter on IT in the recent all-**party pharmacy group report on the future of pharmacy is unnecessarily alarmist. While the report is quite right to recommend that community pharmacists will need full IT functionality and integration to maximise their contribution to NHS patient care, some recommendations need proper examination, and, possibly, reconsidering in light of more current events.

Take the Electronic Prescription Service, for example. The report says: "Much remains to be done if the deadline of the end of the year is to be met." Connecting for Health (CfH) believes it is on target to achieve EPS1 access by this deadline and over 4,500 pharmacy systems have already had technical upgrades to the new system. CfH has announced that over one-third of PCTs have expressed an interest in becoming initial implementer sites for EPS2. Clearly, these PCTs believe there is value in getting the EPS up and running as soon as possible.

My greatest concern, though, relates to the report's focus on IT training and funding. Community pharmacy IT systems uniquely have two core functionalities; one to support the electronic transfer of prescriptions – which is already centrally funded and which is core to all new systems – and the extra functionality that allows easier patient and business management support.

The APPG itself recognises that pharmacy should have some financial liability in this latter functionality, but it concerns me that it now calls on "the Department of Health and PSNC to open discussions on how to quantify and share those costs [of funding for hardware, software, training and time lost to skills development] between the NHS and the pharmacy sector".

As the PCTs rush to get involved in EPS2, implementation day is approaching and there are other, more fundamental issues that pharmacists should prioritise, such as the EPS level playing field. CfH has committed to this, but will the Department of Health really delay rolling out this more successful strand of the NPfIT just because a small number of suppliers or pharmacists are not enabled? At what point will the DH consider that a level playing field has been reached, and force stakeholders into a rollout?

Rather than delegating responsibility for action to DH/PSNC negotiations as the APPG suggests, pharmacists themselves should take control of the situation. You are the customer, so you should be the one leading the functionality agenda. It's time that you got on the phone to your EPS1/2 vendors now.

**Geoff Mackay**
**director, Stirling Consultants**


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Date of preparation: June 2007
BRO-06/034

# Good intentions go up in smoke

PCTs say pharmacy is the first choice for stop smoking services, a C+D poll reveals. So why are so many being left out in the cold? **Max Gosney** reports

Over half of PCT chiefs quizzed in a C+D poll regard pharmacy as the best value provider of stop-smoking services (2). Yet with commissioning of this enhanced service wildly erratic you could be forgiven for recreating a scene from Hollywood blockbuster Jerry Maguire next time you're on the phone to the PCT. Shouting out: "Show me the money!" at the top of your voice may trigger strange looks from patients, but the ploy worked wonders for the film's American football star Rod Tidwell as he grappled for a contract with the sports agent played by Tom Cruise.

Our poll, carried out by Webstar Health, makes frustrating reading for pharmacists. On the one hand the profession is feted as a popular choice with patients and NHS commissioners (1,2). But front-line contractors suggest goodwill is being swallowed up by the gaping hole in many PCT budgets. Bournemouth-based Rajesh Kerai told C+D: "When I approached the PCT they said there was not enough budget as it had already been given to a few other pharmacies. But I've got colleagues in other areas who have been given the funding."

Despite the unpredictability, 64 per cent of the 44 senior PCT staff quizzed reported an increase in the number of smoking cessation services commissioned through pharmacy (3).

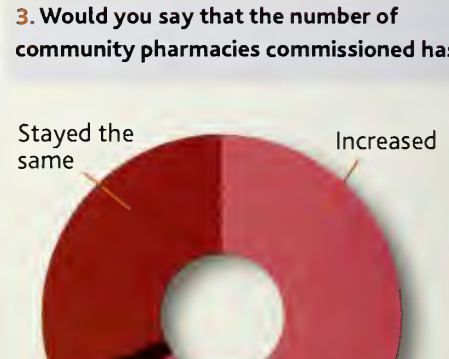
Commissioning of quit-smoking initiatives through other stakeholders was also up by 59 per cent as the NHS gears up for a possible increase in quit attempts following the arrival of the smoking ban in England (5). However, only 40 per cent of PCTs said this will be matched by a rise in their 2007/08 budgets (4). Survey results also suggest a lack of communication between pharmacists and commissioners. Eighty eight per cent of PCT staff claimed that they rather than LPCs or local pharmacists are the driving force behind enhanced services development (6). It's a situation that requires a rethink if the government is to make the most of pharmacy's enormous potential according to representative bodies. Georgina Craig, CCA policy lead for commissioning, said: "Given that the survey respondents agree that pharmacy services are especially good value for money it is surprising that the numbers gearing up to meet that challenge by commissioning more support through pharmacy is not higher. We would like to see smoking cessation become an advanced service."

## Results of the C+D poll on PCT smoking cessation plans

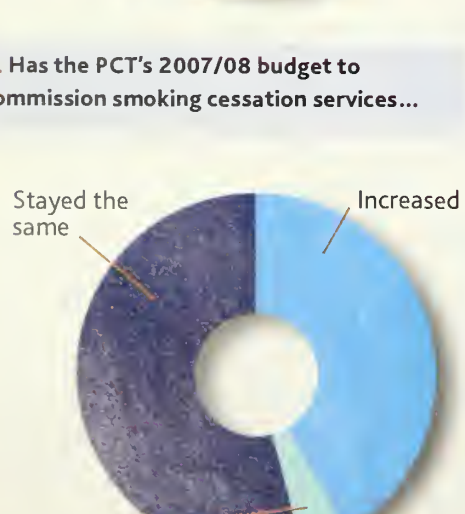
**1. Where do you think that smokers wanting to quit are most likely to go for help?**


**2. Who do you consider the best value providers of smoking cessation services?**

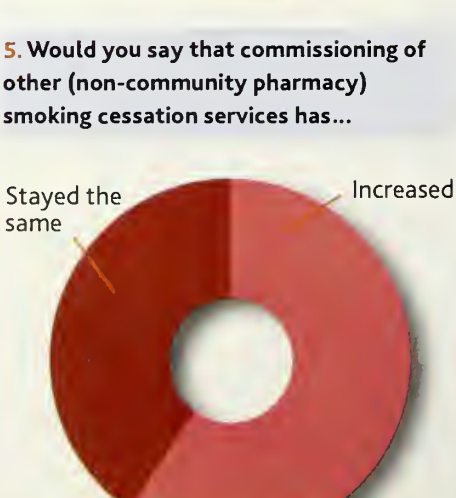

**3. Would you say that the number of community pharmacies commissioned has...**



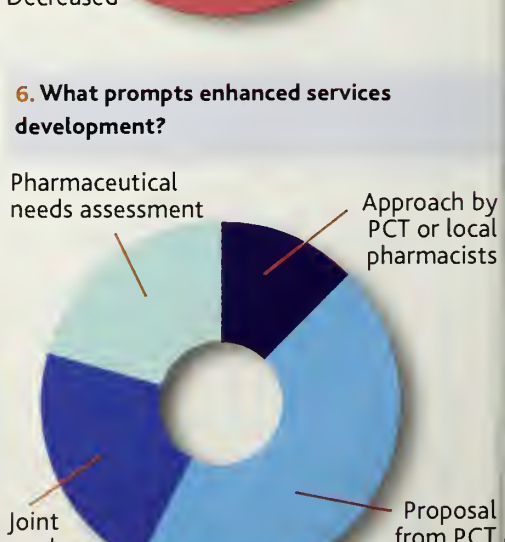

**4. Has the PCT's 2007/08 budget to commission smoking cessation services...**




**5. Would you say that commissioning of other (non-community pharmacy) smoking cessation services has...**




**6. What prompts enhanced services development?**



# A proposal

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# Comment from the editor

**So the members of the Professional Regulation and** Leadership Oversight Group have been announced. It's already known as PRLOG (pronounced 'prologue'), which is fitting, as it is the forerunner to the main event. Obviously someone in the DH has a sense of humour.

It has a difficult task in front of it. Given that pharmacy has lived with the last major change to its regulation for more than 70 years, the importance of the task ahead for the group should not be underestimated. Working out how the General Pharmaceutical Council can be established and advising ministers on their findings is only half the battle, which will be led from the front by England's chief pharmaceutical officer Keith Ridge. The tricky bit will be influencing the outcome of the debate that will determine how the pharmacy profession will be led, and Peter Noyce, professor of pharmacy practice at the University of Manchester, will be "leading on regulatory support".

It's important to remember that PRLOG will be reporting its recommendations to ministers – and if they don't like what they see, they won't be recommending it, never mind supporting a bid for royal college status. To ensure the best outcome for all, the pharmacy profession needs to engage with PRLOG, and with the RPSGB through its consultancy (which needs to share its findings with PRLOG), to ensure the profession has input into the change process.

Some quarters of the community pharmacy sector have expressed dismay about not having a place on PRLOG. No-one likes being left out of the team, but the larger the group, the harder it is to come to any kind of decision. And faced with these particular challenges, the decision-making process could become lengthy indeed.

> "The importance of the task ahead should not be underestimated"

# Your views

## Don't fear the future

Alison White says technology should help not hinder business development

**Many of the challenges faced by** community pharmacy are not unique to the sector. All businesses are facing a tide of change; any business ignoring those changes related specifically to the advancement of technology does so at its peril. Indeed, how well a business can ride the wave of change will determine whether it sinks or swims in the modern environment.

As a trade association, the National Pharmacy Association has two jobs to do: to make sure we provide relevant solutions to the challenges our members face, and to show leadership. By embracing change ourselves, we can gain better understanding and can therefore talk authoritatively.

So how can we cope and even thrive with technological change? Technology should provide either a competitive advantage – "I can dispense this prescription more quickly," "My customers can access this service online," or a commercial benefit – "I can remove this task from my workload." Technology delivers most benefit when it does both.

We know pharmacists are increasingly becoming connected electronically to the wider world. Getting up to speed with electronic transfer of information represents a major challenge for NPA members, particularly when the availability of information seems so limited. Well-worn and understood processes ingrained into the psyche for many years can potentially be removed overnight. The necessary changes in behaviour and skills should not be underplayed, substantial investment is required to realise the full benefit of the new technology.

The introduction of technology can act as the trigger to review the skills available in the pharmacy team. If the required tasks change, then it follows that the mix of skills will also need adjustment. It is important for any business to make sure the match of skills to tasks is as operationally efficient as possible. Creating excitement and interest in getting the best from new systems is a key aspect of realising commercial advantage. Involvement of the staff themselves will help a great deal in achieving success in IT developments.

The NPA continues to embrace new technology by deploying IT that enriches our knowledge of members' needs, knowledge that will allow us to anticipate the products and services required by the sector.

We are also keen to ensure as many services as possible are available online. For example, providing the information department's database on www.npa.co.uk means we now share our intellectual property with members, allowing them to get answers to pharmacy questions without having to pick up the phone.

What's interesting is the knock-on effect this has on our calls, with some members asking more detailed questions as the basic information is now available online. You probably see this effect reflected in your own practice as well: patients often approach the pharmacy armed with a sheaf of internet downloads meaning their enquiry may well stem from a more informed position.

The NPA can also realise commercial advantage from technology, so that community pharmacy owners can continue to enjoy excellent value for money from NPA membership.

We will always align the use of technology to our mission – to do everything possible to ensure our members' professional and commercial success.

**Alison White is CEO of the NPA**

# Xrayser

## Dreading electronic chaos

**The first five PCTs to implement EPS Release 2 are expected to go** live in October. I'm glad that my pharmacy is not in one of them. I'm dreading the confusion and chaos that will result from electronic prescriptions, and the more problems that can be ironed out in these early adopting PCTs the better.

I spend far too much time searching for prescriptions as it is – the national spine will be just one more place to look. My prescription hunt already includes the PMR, my 'dispensed' shelves, in the CD cupboard, in the fridge, in the pile just arrived from the surgery, in the patient's hand, the delivery driver's van, the owings book, the repeatable prescriptions file, the GP surgery and the record of prescriptions returned for amendment. It often takes longer to track down a prescription than it does to dispense it and carry out an accompanying MUR. If I also have to delve into the electronic ether in search of the elusive green form I will have even less time to do anything useful. Patients will expect their e-prescription to be waiting for them when it's more likely that the GP hasn't sent it anywhere or sent it to the wrong pharmacy, or got so frustrated with the whole system that he hand-wrote a prescription and left it at reception.

Prescription hunting is made more difficult still by the number of different types of form. I already receive around a dozen different types every day – amalgamating these into one or two would have made things easier come the electronic D-day. I still expect to receive paper prescriptions for CDs, private items, supplementary and independent prescribers, veterinary products, patients travelling away from home, hospital prescribers and patients from drug treatment clinics, to name but a few. Any benefits this new technology might bring are dubious. Time saved in fewer keystrokes in the dispensary will be cancelled out by time wasted looking for prescriptions. Fewer keying-in errors will easily be offset by harm done to patients who couldn't take their medication simply because their prescription was 'not found'. The implications of a power cut/software problem/virus attack/new member of staff at the surgery who doesn't know how the computer works don't really bear thinking about.

And of course there's the paperwork. The irony of computer technology is that most documents are printed out and you end up with more bits of paper than before you were 'upgraded'. I'm secretly hoping that the rollout will go disastrously wrong, the idea will be scrapped and I can remain in my paper-laden comfort zone.

## A royal college – is it worth it?

**Creating our royal college sounds fraught with so many** difficulties that decisions like who should be in it or what it should do appear straightforward (C+D, July 14, p8). Call me a quitter, but when I get to a point in a process where the odds stack up against me like that I decide that I'm probably taking the wrong course of action and attempt something a little more straightforward.

It seems unlikely that the government will foot a £13 million bill nor that two-thirds of members will vote for losing their assets. I don't think anyone believes the end will justify the means.



Hospital Report

# Time for a recruitment shake-up

**The revelation that the eight** individuals arrested for the London car bombs and the attack on Glasgow Airport have all been connected with the NHS came as a shock to many.

It surprised even more that several of them were doctors. Surely all doctors pledge an oath to do no harm? Those arrested appear more hypocritical than Hippocratic. Actually, not all newly qualified doctors do take the oath or one of its more modern forms. Most graduation ceremonies do, however, include a commitment to do good and do no harm.

The government's immediate response is that the NHS must look at its recruitment practices and consider "profiling" candidates – whatever that means. The proposal

> "Surely all doctors pledge an oath to do no harm?"

merits careful deliberation, though. Will everyone applying for any post in the NHS need to be vetted? To exclude any allegations of discrimination, it would have to be. You cannot "profile" only those of Middle Eastern origin, or members of a particular religion or profession. Only overseas applicants? It would have to be all overseas applicants, including those from the EU, Australia etc. It would not detect UK residents or those who attended schools and/or universities in the UK. And think of the extra administration!

Some sections of the press have expressed surprise that there are so many overseas doctors working in the NHS today. Can the UK not produce enough doctors itself? A look at the mess of the junior doctors job placements created by Modernising Medical Careers should answer part of that question. UK junior doctors can't get jobs here and are emigrating!

**Written by a senior hospital pharmacist**

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C+D Clinical

# Lipid-lowering case studies

The first in a series of articles on cardiovascular topics looks at on lipid-lowering drugs

## Key points

- High blood cholesterol is only one of many risk factors for CVD; others must be taken into account to calculate total risk in an individual.
- Simvastatin 40mg daily is the most cost-effective statin for most patients.
- Patients may be switched to other statins to avoid adverse effects or to achieve specific target cholesterol levels.
- A significant fall in cholesterol achieved by an initial statin regimen is likely to produce the most clinical benefit and be more cost-effective compared with the gain obtained by prolonged and exacting manipulation of drug or dose for the sake of reaching a specific lipid target.
- Combination treatment with a statin and a fibrate is common for patients with a mixed hyperlipidaemia.
- The number of patients who report muscle pain when taking a statin is likely to be disproportionately higher than the number who sustain pathological muscle damage.

## The College of Pharmacy Practice

This course (module 1412), in association with multiple choice questions being published in C+D August 4, provides one hour's continuing education

## Reflect

Do you know why some people are treated for raised cholesterol, while others with higher levels might not be? Before reading the full text of this article look at Case 1 – what would your response be? Is it always wrong to use statins and fibrates together?

## Plan

By reading these case studies you should be able to give better advice to people with lipid abnormalities and when carrying out MURs of people taking statins.

CPD This article can help in the following CPD competencies: G1a, G1c, C1b, C3e. See www.tinyurl.com/194zu

Clive Edwards

## CASE STUDY 1: When should raised cholesterol be treated?

**Mr A is a 45-year-old builder who smokes, drinks and is mildly obese. He presents his usual repeat prescription for his irritable bowel syndrome and asthma treatments.**

**He has been screened recently at his GP practice and told that his total cholesterol was 6.5, which was nothing to worry about.**

**His workmate, five years younger, has a cholesterol level of only six, but he was given some tablets to lower it. Mr A cannot understand this and asks you if it is just because his mate saw a different doctor, and whether he should seek a second opinion.**

A high blood cholesterol level is only one risk factor for cardiovascular disease. Unless it suggests a familial or hereditary hyperlipidaemia, it is a fairly meaningless marker in isolation. Mr A's other risk factors are that he is a smoker, drinks more than 28 units of alcohol per week and is overweight. You should explain that several factors must be taken into account. He has no history of cardiovascular disease and his blood glucose and blood pressure were also checked.

The most likely explanation for the different approach is that his workmate has some other risk factor(s). Mr A tells you his workmate takes tablets for diabetes.

You could show him the JBS2 risk charts at the back of the British National Formulary to demonstrate the other factors taken into account when calculating risk. For patients like Mr A, who do not have cardiovascular disease, these are:

- gender
- smoking status
- age
- systolic blood pressure
- high ratio of total cholesterol: HDL-cholesterol.

Other risk factors that do not appear on the charts are:

- family history of heart disease
- south Asian origin
- high blood triglyceride level
- increased waist circumference.

If a patient already has occlusive vascular disease such as angina, a previous myocardial infarction or stroke or has diabetes (current practice is to regard diabetes as a vascular disease, in this context), then a statin would be recommended according to most existing guidelines[1], regardless of the presence of any of the above risk factors.

Although Mr A can be reassured, this is a perfect opportunity to talk about lifestyle issues such as smoking cessation, exercise and diet.

## CASE STUDY 2: The need to change statins

**Mr C has regular repeat prescriptions for his angina and hypertension as well as a changing prescription for a statin. Five years ago he was started on atorvastatin 20mg daily and the dose later increased to 40mg. Recently his doctor changed him to simvastatin 40mg, then 80mg. His most recent prescription was atorvastatin 40mg plus ezetimibe 10mg. What is the likely explanation for these changes?**

For more than a decade, clinical trials have shown the merit of all the statins available today. On a dose-for-dose basis, atorvastatin was the most potent drug available in reducing blood cholesterol levels at the time Mr C started treatment, and it was a popular choice among clinicians. Since then, several trials have shown its clinical effectiveness in reducing cardiovascular events. However, in 2002 the results of a large multicentre clinical trial, the Heart Protection Study, were published in The Lancet. These showed that, for patients with existing cardiovascular disease, simvastatin 40mg daily lowered the risk of myocardial infarctions and strokes by more than one quarter. This reduction in cardiovascular events occurred regardless of whether the baseline total and LDL-cholesterol levels were high or low. As a result, many clinicians began to prescribe simvastatin 40mg daily as the first choice for all at-risk patients, regardless of their blood cholesterol.

In 2003 the UK patent for simvastatin expired and the drug's cost fell dramatically, putting it in pole position as the most cost-effective statin, a feature later endorsed by Nice guidance. However, in 2004 the new contract gave GPs an incentive to achieve certain targets in the quality and outcomes framework (QOF), one of which was to maintain total cholesterol (TC) levels below 5mmol/l in patients with coronary heart disease. Not surprisingly, GPs tend to work to this target. About 70 per cent of patients can achieve a TC level less than 5mmol/l with simvastatin up to 80mg daily.

Mr C's story was: five years ago, atorvastatin 20mg was prescribed – TC fell from 8 to 6mmol/l. A dose increase to 40mg achieved a further drop in TC to 5.4mmol/l.

A year ago, local PCT guidelines encouraged GPs to use simvastatin 40mg in line with Nice's recommendation about cost and so Mr C's prescription was changed to simvastatin. His TC rose back to 6mmol/l so his GP increased the dose to two 40mg tablets, lowering his TC slightly to 5.6mmol/l.

To meet the QOF target, the options were to increase his previous dose of atorvastatin to 80mg or introduce an additional drug. The GP had seen patients with adverse effects at this higher dose of atorvastatin and so decided to add ezetimibe, which has a different action from the statins by reducing absorption of cholesterol from the intestine.

If, as a result of this change, the cholesterol profile only changes modestly, further manipulation of either drugs or doses may not produce any more significant clinical benefit.

## CASE STUDY 3: Statins and fibrates together

**Mrs D is 45 years old and has been taking antihypertensive drugs for several years. Her recently diagnosed type 2 diabetes is being treated with metformin. Her lipid chemistry is: TC = 6.9; LDL-C = 4.2; fasting triglycerides = 6.2mmol/l (normal maximum is about 1.8 mmol/l). She comes to you with her first prescription for simvastatin and fenofibrate. Why has she been prescribed a fibrate and a statin, as the computer is issuing a warning of a drug interaction between the two?**

Current thinking is that patients with type 1 or type 2 diabetes who are more than 40 years of age are at sufficient risk of cardiovascular disease to be treated with lipid lowering agents.

The Heart Protection Study showed clinical benefit in diabetic patients treated with simvastatin, and thus this choice is appropriate for Mrs D.

Her TC and LDL-C levels are high and treatment targets are likely to be set at TC less than 5.0 and LDL-C less than 3.0.

Blood triglyceride levels are usually raised in untreated diabetes and are associated with high LDL-C and low HDL-C and atherogenic disease. In addition, hypertriglyceridaemia can cause pancreatitis.

Thus Mrs D has a mixed hyperlipidaemia, requiring treatment with both a statin (for the hypercholesterolaemia) and a fibrate (for hypertryiglyceridaemia).

Should the pharmacist ignore the warning of an interaction between these two drugs? The GP should also have seen the same warning on his computer screen. It is possible that Mrs D has seen a hospital specialist who has recommended this regimen.

Statins and fibrates can each cause myopathy (muscle damage) but this is uncommon. A combination of the two drug types increases the risk. This can progress to rhabdomyolysis, a potentially fatal but very rare condition in which the myopathy leads to acute renal failure caused by accumulation in the blood of muscle breakdown products such as myoglobin; this spills into the urine and forms nephrotoxic breakdown products.

The currently available statins are much safer in this respect than cerivastatin, which was discontinued in 2001 because it was associated with a high risk of rhabdomyolysis. Similarly the most implicated fibrate has been gemfibrozil, which is used less frequently nowadays.

It is thought that these drugs may damage the membranes of muscle cells, causing intracellular contents to leak into the circulation, including potassium, creatinine kinase and the protein, myoglobin. At the same time, sodium ions leak into the cells from the extracellular fluid and this activates the Na+, K+ -ATPase pump in an attempt to rectify the ion imbalance. To operate at this higher level, the pump requires more energy in the form of ATP. There is a theory that statins may inhibit the biosynthesis of coenzyme Q10 and thus prevent the formation of ATP, which would result in impairment of this repair process (see Case 4).

### Myopathy

Patients should report any muscle pain, weakness or tenderness. They may notice darkened urine, caused by

the haem component of myoglobin.

To confirm the diagnosis, blood chemistry results would show raised serum creatinine kinase and potassium, and abnormal renal function. A urine dipstick would be positive for blood.

As with any adverse effect, if a doctor tells patients to look out for a symptom, the chances are that a large number of them will find it! Thus there are many false positives and a number of patients will change statins in the hope that another one will not produce the same symptoms. There is little substantive evidence to support such switching, but the effect does seem to be dose-related.

So what is the incidence of rhabdomyolysis with lipid lowering drugs? A Bandolier[2] review in 2005 suggested a risk less than one per 10,000 per year for atorvastatin, pravastatin and simvastatin and a risk of death following rhabdomyolysis of one per 100,000 per year for all patients treated with either a statin, fibrate or a combination.

## CASE STUDY 4: Is coenzyme Q needed with statins?

**Mrs B is a nurse whose husband has just started taking a statin. She has read that patients on statins should take a supplement of coenzyme Q10. Her husband's GP was not aware of any clinical significance of this supplement.**

Coenzyme Q10 (Co-Q10) is a co-factor for various key enzymes including those that produce energy in the form of adenosine triphosphate (ATP) in cell mitochondria. It is produced endogenously and is also obtainable from the diet, mainly in meat and oily fish but also nuts and vegetables.

The relative contribution of the two sources (ie endogenous Co-Q10 and that absorbed from the diet) is unknown, but Co-Q10 is claimed to have free radical scavenging properties and is thought to prevent oxidation of LDL-cholesterol, lowering its atherogenic potential. There have been reports that patients with various cardiovascular disorders have low levels of Co-Q10, and trials have shown supplements brought clinical improvement in patients with heart failure, angina and even hypertension.

There have been some reports that statins lower Co-Q10 levels. This is a feasible hypothesis because there is a common pathway in the biosynthesis of both Co-Q10 and cholesterol, which may be blocked by statins. However, the evidence that this has any clinical significance is conflicting and there is not enough at present to justify its use as a supplement to be taken with statins. Nevertheless, if Mrs B is persistent and wants to make a purchase, it should do no harm.

Clive Edwards BPharm, PhD, MRPharmS, is a former lecturer in clinical pharmacy at Newcastle University and a PCT prescribing adviser.

References:
1. Nice Technology Appraisal 94. www.nice.org.uk
2. Bandolier, 2005 (Jan) Rhabdomyolysis with statins. 131-132.

## Continuing Professional Development CPD

### Act

- High blood cholesterol is only one of many CVD risk factors. Find out more about others. There are many sources: you may like to start with http://tinyurl.com/2uxesg and http://guidance.nice.org.uk/TA94/guidance/word/English
- A patient presents with his/her blood chemistry and asks you to interpret the results in terms of the "fatty things in the blood". What blood components are significant? What are the "normal" values? At what level do they constitute a CVD risk? Find a suitable table giving the range of these components and copy it into your practice workbook.
- Record the next 20 patients being changed from one statin to another, and why they have been changed. Do the reasons relate to the facts in the article? Look at the Nice site above for a comparison of all statins licensed in the UK to treat hyperlipidaemea. Does this throw any new light on the subject?
- How many of your patients take a statin and a fibrate? How many take just a fibrate? Find out why each is prescribed their regimen. Can you draw any conclusions from this small sample? Do the reasons agree with the facts stated in the article?
- Talk to your local friendly doctor. Ask about how the quality and outcomes framework (QOF) affects his/her practice and prescribing habits? Do they think it improves clinical outcomes? Do you?

### Evaluate

When the next patient presents you with a blood lipid analysis will you feel more able to discuss their results? And how about patients who have changed statins? What would you say to them?



## Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the August 4 issue, which will cover this week's CPP-accredited module, together with those in the July 7 and 14 issues.

These will cover:
- Peptic ulcer (1410)
- Baby skin conditions (1411)
- Case studies on statins (1412)

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

Chemist + Druggist in association with Genus Pharmaceuticals

C+D

GENUS PHARMACEUTICALS

A Practical Approach...


**At the Update Pharmacy, Mark Davis, a** man in his mid-50s, has been referred to the pharmacist, David Spencer.

"Why have I got to talk to you?" asks Mr Davis, rather annoyed.

David replies: "Hannah here called me because she thought you had been in for this ibuprofen gel quite a lot lately, and she says that you also buy co-codamol tablets from time to time."

"So what's it to you? There's no law against it, is there? If I wanted to, I could just go to the supermarket, help myself off the shelf, take it to the checkout and buy it no questions asked. What's this third degree for?"

"Look, Mr Davis, you've been coming here for a long time for your prescriptions and it's my job to take an interest in your wellbeing. I just want to make sure that you haven't got a serious problem. If I know what the trouble is, perhaps I can help you with it."

"I'm sorry," says Mr Davis, looking slightly shamefaced. "I have got a bit of a problem, but I think I'm staying on top of it."

"Can you tell me what it is?"

"It's my back and leg. I was made redundant from my accounts clerk job a few months ago. The only work I've been able to get is as a warehouseman, and I'm having to do a lot of lifting and carrying of heavy boxes. It seems to have brought on backache across the top of my pelvis and shooting pains down my left leg. I've had a bit of back trouble ever since I had a car accident 10 years ago, and it's getting worse now. But I'm keeping it more or less under control. I've got to – I can't afford to take time off and risk losing this job too."

**Questions**

1. What is the likely cause of Mr Davis's pain?
2. What symptoms or factors would make David refer Mr Davis to his GP immediately?
3. Is there any treatment or advice that David can offer?

Answers →

CPD

This article can help in the following CPD competencies: G1a, G1h, C1b, C1f, C3e. See www.tinyurl.com/194zu

# ICS can cause pneumonia in COPD

Elderly patients with COPD who use inhaled steroids are at increased risk of pneumonia, hospital admission and death, a large retrospective study has confirmed.

Triggered by results from the TORCH study showing an increased incidence of pneumonia in this group, the study examined the records of 175,906 patients with COPD in Quebec from 1988 to 2003.

Writing in the American Journal of Respiratory and Critical Care Medicine, the study's authors found a rate ratio of 1.7 for pneumonia associated with current use of inhaled corticosteroids, and 1.5 for pneumonia hospitalisation followed by death within 30 days.

**For more information:**
Am J Resp Crit Care Med 2007; 176: 162–6

# Rosiglitazone advantages questioned

A Cochrane systematic review of 18 trials has failed to find evidence that rosiglitazone leads to better outcomes than other therapies.

The 18 trials including 8,432 subjects found that $HbA_{1C}$ levels in patients treated with rosiglitazone were no better than those seen in patients taking other antidiabetic drugs.

However, the review confirmed an increased risk of oedema known to be associated with rosiglitazone treatment, and also reported some weight gains of up to 5kg. Also, in one large study it found patient evidence of increased cardiovascular risk and a raised incidence of broken bones.

Patient outcomes such as mortality, diabetes-related morbidity and quality of life were not addressed in most of the studies.

Rosiglitazone maker GSK said the review lacked new data, including interim results from the RECORD trial. It also disagreed strongly with a suggestion that further trials of rosiglitazone might be unethical.

**For more information:**
www.thecochranelibrary.co.uk

# Infection protein may cause sleep

Immunologists at the University Hospital in Zurich believe they have discovered one of the mechanisms that make people tired whenever they are ill with an infection.

The cause, they say, is a protein called tumour necrosis factor alpha, which triggers inflammation in infection. The research reveals it down-regulates expression of genes associated with diurnal rhythm.

The report is in the US journal Proceedings of the National Academy of Science.

## In brief

### Don't miss your chance to win £100!

Please fill out our short online questionnaire explaining what you like and don't like about C+D's clinical content, including the clinical news section, Pharmacy Update articles and their associated CPD element.

To make the whole thing more interesting, one lucky pharmacist reader who completes the questionnaire will win £100.

The deadline for completion is July 31. Go to www.dotpharmacy.com/upmain.html

## A Practical Approach... this week's answers

1. Sciatica, caused by the trapping of the root of the sciatic nerve by a prolapsed intervertebral disc.
2. If associated with other symptoms of illness, or with neurological symptoms such as numbness or tingling in the legs or feet; any problems with bowel or bladder function; severe pain at night; OTC treatment becoming ineffective or requiring significant increase in use.
3. There is no other treatment that David could advise. The OTC medicines seem to be keeping the symptoms more or less under control, but they are likely to worsen if Mr Davis has to continue lifting heavy loads and he may find himself incapacitated and unable to work. Perhaps the best advice that David can offer Mr Davis is that he should try to find a less physically demanding job.

# choice

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## In brief

**The type of dressing used** under multilayer compression dressings to treat venous leg ulcers has no significant effect on healing, a review published in the BMJ has concluded. A comprehensive literature search apparently found no evidence that hydrocolloids had any advantage over simple non-adherent dressings.

**Evidence has emerged** that in some patients breast cancer drug tamoxifen can help some cancers to proliferate by shielding them from the immune system. Authors writing in the journal Oncogene have suggested this may be the reason tamoxifen is less effective in patients whose tumours contain many oestrogen receptors. Oncogene 2007; 46: 4106.

**Brent PCT has issued** a useful checklist for use by GPs when prescribing methadone and buprenorphine. http://tinyurl.com/yt3lkg

**Draft Nice guidance** suggests pharmacists should advise all women who may become pregnant of the benefits of taking folic acid, even if they are eating foods fortified with the vitamin. It also recommends pharmacists use supplementary sources of information when dispensing to breastfeeding mothers, and use the BNF only as a guide. www.nice.org.uk

**JAMA has reported a review** showing that incretin-pathway treatments for diabetes offer an alternative to current treatments. The treatments have modest efficacy, the review concludes, but have a favourable weight-change profile.

**Children at risk of recurrent** urinary tract infection do not benefit from antimicrobial prophlaxis, and may suffer from infections caused by resistant organisms, reports a study in JAMA. JAMA 2007;298:179-86.

**Spraying salty water into the nose** is effective in reducing symptoms of pain and congestion in patients with persistent symptoms, a Cochrane review has concluded. www.thecochranelibrary.co.uk

**Another Cochrane review** has found a lack of data supporting dietary treatments in controlling blood sugars in newly diagnosed type 2 diabetes. However, it has found strong evidence showing exercise improves blood sugar control. www.thecochranelibrary.co.uk

**Anastrozole (Arimidex)** is a cost-effective treatment for early breast cancer compared with the established alternatives, suggests new data published this week in the British Journal of Cancer. Criteria used were similar to those of Nice. Br J Cancer 2007; 97:152-61.

# Slime mould could unlock pain secrets

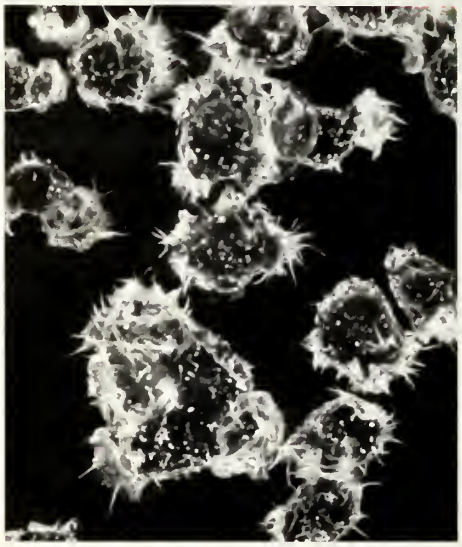
The slime mould Dictyostelium may help to unlock some of the secrets of pain, University of Manchester researchers hope.

Writing in Nature this week, they revealed that they had examined P2X molecules found in the primitive slime mould Dictyostelium, and found they are partially similar to P2X receptors, which cause pain in humans.

The team found a 10 per cent similarity between human P2X and the slime mould equivalent, and deduced that the similar parts are likely to be those involved in regulating pain in humans.

Inhibiting P2X could revolutionise the way chronic pain conditions are managed, said one of the researchers.

**For more information:**
Nature 2007; 448(7150): 200-3



**Similarities between the slime mould and human P2X molecules may open new avenues for research into pain management**

# Aspirin review finds less is more

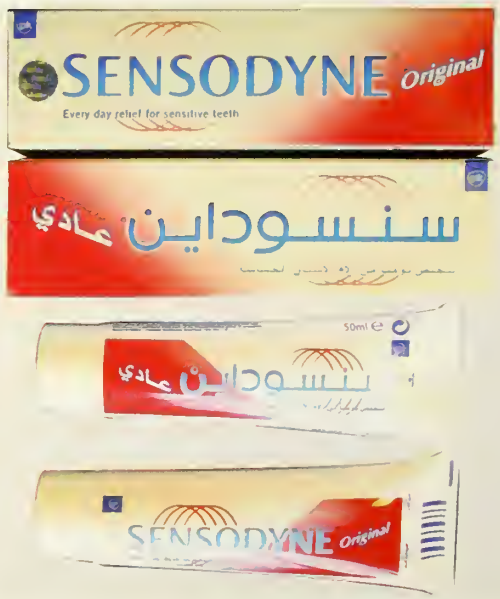
A systematic review of aspirin dosing published by JAMA has concluded that doses of more than 75–81mg/day are not more effective in preventing cardiovascular disease, but are associated with an increased risk of bleeds.

The review searched the databases for English-language research giving dosages and outcomes, and included prospective studies of patients with established heart disease.

The results showed that the available evidence, which derives mainly from secondary-prevention observational studies, supports 75-81mg/day dosing.

**For more information:**
JAMA 2007; 297: 2018–24

# Counterfeit toothpaste warning




The MHRA this week warned pharmacists of batches of potentially dangerous counterfeit tubes of toothpaste in the supply chain.

The counterfeit products are labelled Sensodyne Original and Sensodyne Mint 50ml, and have a combined Arabic and English livery.

They are said to contain diethylene glycol at levels that could be toxic to young children, and anyone with impaired liver or kidney function.

The MHRA said that there have been no reports of incidents relating to the counterfeit paste.

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RIGHT GUARD

## C+D's one minute interview with ...

Katharine Osmond, brand manager for Panadol

**Who buys your brand?**
Panadol customers tend to be female, slightly upmarket and of an older age demographic.

**Why should pharmacies stock Panadol?**
The UK's ageing population is increasingly encountering health issues for which paracetamol is a suitable form of pain relief. As a result, GSK is committed to driving the Panadol brand forward in the UK as we recognise a huge opportunity for the brand.

Many of our products provide an added consumer benefit, eg Panadol NightPain eases pain experienced at night and Actifast works twice as fast as standard paracetamol.

Panadol recently won the accolade of superbrand.

**How can pharmacies sell more?**
We are hoping to do more and more work with pharmacists and pharmacy assistants, offering them training tools to be able to identify whether paracetamol is the best choice and offering Panadol as a brand they know they can trust.

**Do you have any brand innovations? Or a fantasy new product?**
An instant pain reliever in the Panadol range would be my dream innovation! GSK is investing heavily in innovation and there are some ideas in the pipeline that we're really excited about that will help differentiate Panadol from generic products.

Interested in appearing in C+D's one minute brand manager interview? Contact Lesley Ribbens on 01732 377600 or email lribbens@cmpmedica.com

# Just For Men makes TV return

National TV advertising for hair colorant Just For Men begins this week. Continuing until mid-August, the activity forms part of the brand's £4 million promotional budget for 2007.

Nine shades are available, complemented by brush-in colour gels for beards and moustaches. The vitamin-enriched colorants target only grey hairs and one application lasts up to six weeks, claims Combe International.


**Product info:**
Combe International
Tel: 0208 6802711

# Smelly vision on television

OdorEaters Foot & Shoe Spray returns to televisions screens this week as Combe International's £1 million promotional spend on the brand continues. The ad will appear until mid-August.

With antibacterial and antiperspirant properties, the dual action spray is the most recent addition to the OdorEaters footcare brand, further including Trainer Tamers, Ultra Comfort and Super-Tuff odour destroying insoles.


**Product info:**
Combe International
Tel: 0208 6802711

# Sea-Band study shows promise

Sea-Band acupressure wristbands have been shown to be beneficial in reducing nausea and vomiting in chemotherapy patients.

In a UK-based study of 36 breast cancer patients undergoing their first chemotherapy treatment, those using Sea-Band and anti-emetic drugs experienced a nearly 50 per cent reduction in nausea and vomiting symptoms than those receiving anti-emetics alone. Distress caused by the symptoms was reduced by up to 80 per cent within the five days following chemotherapy in the combination group.

The research was published in Complementary Therapies in Medicine, 2007, 15; 3-12.

**Product info:**
Sea-Band Ltd
Tel: 01455 639756

# Cuticura cuts its TV teeth

Hand hygiene brand Cuticura makes its television debut this week in a national campaign running until August 19.

The ad features the use of Hand Hygiene Gel variant on a train and aims to convey its convenience, portability and germ-killing properties.

The £1.5 million television advertising campaign breaks on July 23 and is running in all areas except GMTV.


**Product info:**
Keyline Brands
Tel: 01732 897757

## Products advertised on TV next week

**Bepanthen:** All areas
**Bio-Oil:** All areas, except GMTV
**Canesten:** All areas
**Cuticura:** All areas, except GMTV
**Deep Freeze Patch:** All areas, except GMTV, C4, Five
**DulcoEase:** GMTV, Sat, five
**Frontline:** GMTV, Sat, five
**Jungle Formula:** GMTV
**Just For Men:** All areas
**Kool 'N Soothe Migraine:** C4, five
**Nicorette:** All areas, except GMTV
**Odoreaters:** All areas
**Rennie Dual Action:** All areas
**Seabond:** All areas
**Vagisil:** All areas
**PharmaSite for next week: Oilatum –** windows, **Oilatum –** in-store, **Oilatum –** dispensary
**Pharmacy channel: Piriton, Eurax**

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire


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Reference: 1. AC Nielsen NITRO Total Coverage GB value sales MAT to w/e 19.05.07

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## Indigestion and heartburn remedies

Huge numbers of people in the population suffer at least occasionally from indigestion symptoms, including heartburn, pain or general discomfort in the upper part of the stomach, a sensation of bloating or even nausea.

The condition affects around 40 per cent of UK adults, or about 19 million people (data from Target Group Index). Some 55 per cent of sufferers are women, many of whom experience it during pregnancy, according to figures released by Rennie manufacturer Bayer Cosumer Health, which adds that 58 per cent of sufferers first experience symptoms before the age of 35.

The latest figures from GlaxoSmithKline Consumer Healthcare show a heartburn and indigestion market value of £131 million in the year to May 2007, with a growth of 4.7 per cent a year.

Within the overall figures there were some interesting trends, with antacid sales rising by 5.9 per cent following new launches, while PPI sales fell by 9.3 per cent. $H_2$ antagonists slipped slightly by 0.8 per cent.

Jay Banerjee, Bisodol product manager with Forest Laboratories, tells a similar story. Forest Labs' figures show that while the overall numbers of products sold remain static, the value of the market is rising 2.9 per cent per annum (tablets 3.2 per cent, liquids 2.1 per cent) driven by new product developments. "The liquids are mainly driven by Gaviscon," he told C+D, "while Bisodol Extra, Rennie Fruit and Gaviscon Double Action have all had very good launches."

The key changes in the market have been the introduction of double-action remedies including both antacid and alginate elements by many of the manufacturers, and the supermarkets which are the fastest-growing outlets in this sector.

Mr Banerjee says supermarkets are achieving their growth by driving heavy volume into the category via promotions.

# Hard to stomach

**Gavin Atkin** finds indigestion sufferers often prefer to confide in a pharmacist than a GP

## Causes of heartburn

Most patients have some knowledge of what causes their symptoms, and the triggers can be remarkably varied. Among foods, orange juice, bread, coffee, cucumber and rich and spicy meals commonly trigger spells of indigestion. Overindulgence in food and alcohol generally are another common cause, and lead to significant increases in sales around feast times such as Christmas and the new year.

Other factors may be smoking and being overweight, high stress levels, and eating shortly before sleeping at night. Perhaps of particular significance to pharmacists, indigestion symptoms may be due to medications and supplements such as NSAIDs, aspirin and glucosamine among many others, although patients should not stop taking prescribed medicines without discussing the issue with their doctor first.

Patients with indigestion symptoms frequently do not consult their GP, partly because they feel their condition is likely to be regarded as trivial but also because they expect to be told that their symptoms are self-inflicted, and that unappealing lifestyle changes are required. Not all consultations will result in a sale: there could be underlying problems that merit a GP consultation. Although most of the time you will be able to offer advice on prevention or assist patients seeking to buy antacids, $H_2$ receptor antagonist and proton-pump inhibitor treatments.

For those potential GP referrals, the mnemonic ALARMS may help you remember some of the possible alarm symptoms: **A**naemia, **L**oss of weight, **A**norexia or early satiety, **R**ecurrent symptoms, **M**ass/melaena (dark stools stained black by blood from high in the digestive tract) and **S**wallowing difficulties.

In addition to this list, a GP or hospital specialist will also be looking for bleeding from the stomach and jaundice.

In discussing these issues with customers, it is important to be aware that 90 out of every 100 people diagnosed with stomach cancer are over the age of 55, and the chance of a person with indigestion who is under 55 having stomach cancer is one in a million.

However, NHS Direct's advice is that patients should be referred to their doctor if:

- They have taken an indigestion remedy continuously for four or more weeks.
- They are 45 years or older with new or recently changed symptoms of indigestion.
- They have unintended weight loss in association with indigestion.

The top five perceived causes of indigestion and heartburn

- Eating
- Stress
- Alcohol
- Lack of exercise
- Medical conditions

## OTC treatment

Heartburn and other indigestion pain is due to 'acid in the wrong place', typically in the oesophagus.

Antacid treatments contain calcium, magnesium and aluminium salts. They come as liquids, or solid or chewable tablets and work by neutralising acid. They should not be taken with other medicines as they may either prevent drugs from being absorbed or may damage tablet coatings.

Alginates form a thick layer on top of the stomach contents, preventing excess acid from rising into the oesophagus. They work best when taken after meals and at bedtime. The effects wear off quickly though, so need to be taken frequently.

Combination antacid and alginate treatments are now available from a range of manufacturers.

$H_2$ antagonists and proton pump inhibitors block acid production: $H_2$ blockers act quickly while PPIs can give weeks of remission after typically taking three or four days to give symptom relief.

Patients seeking advice on treating attacks of indigestion can be recommended antacids, alginates or $H_2$ antagonists, while those with recurrent symptoms can be offered omeprazole.

Patients who buy omeprazole can use antacids until the PPIs take effect. Once symptoms improve, the dose should be reduced but may be increased again if symptoms return. No relief within two weeks or continuous treatment for more than four weeks means the patient should see a doctor.

# Advances in coeliac disease

Coeliac disease has perhaps yielded some of the biggest surprises of any area of gastroenterology in recent years.

Whereas it was once thought to be a relatively rare condition, following the development of blood tests we now know that 1 per cent of the general population in the UK has positive coeliac serology. What's more, the majority of these patients have no symptoms, or only mild ones.

One result of this is that the classical symptoms of diarrhoea-steatorrhoea and weight loss due to coeliac disease must now be regarded as a relative rarity. Another is there is now widespread recognition that with only one diagnosed coeliac patient in eight in the population with coeliac serology, there must be an 'iceberg' of undiagnosed coeliac disease in the community.

A major review of the condition last year published in Gut (www.gutjnl.com) concluded that the implications of undiagnosed coeliac disease at a general population level were unclear, not least because the studies so far available have been small and have concentrated on bone mineral density and bodily measurements. The results have shown, perhaps not surprisingly, that positive coeliac serology in a patient with no clinical diagnosis is associated with slight tendency to low bone mineral density (although with a smaller than expected risk of fractures), and measurements in keeping with mildly subnormal nutritional status.

A study in Cambridge showed mild anaemia and osteoporosis in the positive coeliac serology subjects, but also revealed that this patient group was also associated with lower BMI, blood pressure and serum cholesterol, which may suggest that this group may have a reduced risk of cardiovascular disease.

On the negative side, studies have also shown a modest increases in lymphoproliferative malignancies, small bowel lymphoma and breast cancer. The finding that these excess risks often occur in the first year following diagnosis may be taken to suggest that the risk of cancer and shortened life expectancy is low in coeliac patients who follow a gluten-free diet. These issues will require careful epidemiological investigation before screening might, though, be recommended.

## Advances in treatment

A dramatic increase in knowledge of the pathogenesis of coeliac disease has made it the best understood of the human autoimmune disorders, and a variety of therapeutic possibilities have opened up. In the short-term, though, perhaps the most useful change to the management of coeliac disease comes from a trial including five years of follow-up showing that oats are safe for the majority of coeliacs.

The authors of the Gut review concluded that following these results it was reasonable to advise patients to eat oats in the interests of diversifying their diet and encouraging compliance, with the caveats that clinical and immunological responses have been found in a handful of patients, and that there are some doubts about the quality of oats in some countries with respect to gluten contamination.

Mimi Lau, director of professional services at Numark, emphasises the importance of pharmacists liaising with GPs in the management of coeliac disease. "Patients with coeliac disease will need a regular supply of gluten-free products. To help manage these patients the pharmacist should be liaising with the GP to ensure the right prescription is given and check what is actually available to the patient on prescription, as some products are blacklisted.

"Also, as many of the items are bulky, the pharmacy can provide a delivery service and therefore protect customers' business from competition. The pharmacy can also be useful in signposting to support groups, displaying leaflets and information and advising on OTC treatments."

## Shopping behaviour

Customers for indigestion remedies may be making a planned purchase, buying either because their symptoms are frequent or they expect to have an episode of indigestion during a holiday or at a seasonal feast, or may have symptoms and be in urgent need of a remedy.

One consequence of seasonal purchasing is that there is potential for dual-siting at certain seasons. For example, you may wish to offer indigestion and heartburn remedies as part of a Christmas display section in addition to their usual site on the pharmacy shelves; in the summer season you may place them in a holiday section along with products such as sun creams and insect repellents.

Further reading:

1 Advice on stomach symptoms suggestive of cancer: www.cancerhelp.org.uk

2 NHS Direct on indigestion: www.nhsdirect.nhs.uk

# Contains the only formulation to relieve both constipation and bloating


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- With added fennel to relieve bloating

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**ESSENTIAL INFORMATION:** Senokot Dual Relief Tablets, Reckitt Benckiser Plc.
**Active Ingredients – Tablet containing:** Senna Leaves Tinnevelly BP 100mg; Aloes (Cape) BP 45mg; Cascara Bark BP 30mg; Dandelion Root 30mg; Fennel Seed 15mg
**Indications:** For the symptomatic relief of occasional constipation and feelings of bloatedness.
**Dosage Instructions – Adults:** Take one or two tablets at bedtime when necessary.
**Children:** Not recommended. **Contraindications:** None known.
**Precautions and Warnings:** Not recommended during pregnancy. **Side effects:** None known.
**RRP: 20 £3.99, 40 £6.59 (GSL)**
Marketing Authorisation Holder: Potters Ltd. 1 Botanic Court, Martland Park, Wigan, WN5 0JZ.
Marketing Authorisation Number: PL0250/5188R • Distributor: Reckitt Benckiser Healthcare (UK) Ltd.
Date of Revision of Text: November 2006.
**Adverse events should be reported to Reckitt Benckiser on 0500 455 456.**
**Information about adverse event reporting can also be found at www.yellowcard.gov.uk**

Senokot

For further information, go to the healthcare section at
**www.constipationadvice.co.uk**

# Pharmacy Champions


Name
**Ferride Karson**

Pharmacy
**Karsons Pharmacy, Rochester, Kent**

What has he done?
**Started a 100-hour pharmacy**

**What have you set up?**
I have two pharmacies in Kent, one in Chatham and another in Rochester. The Rochester branch was one of the first 100-hour pharmacies in the UK.

We offer EHC, smoking cessation, needle exchange for diabetics and drug misusers, supervised and unsupervised methadone dispensing, MURs and treatment for minor ailments, such as athlete's foot, conjunctivitis, chicken pox and cystitis, at both branches.

We had plenty of interest in our smoking cessation service in the countdown to July 1 and since Gordon Brown pledged to cut VAT on nicotine replacement therapy products.

**What has been the high and low point of setting up the services?**
Operating one of the first 100-hour pharmacies has been a challenge. When we set it up 18 months ago we were doing something that no-one had done before. We bought an old run-down closed Post Office located opposite a GP surgery, stripped it bare and converted it into a beautifully fitted pharmacy with an appropriate consultation room. No other pharmaceutical services were available in the locality for more than 20 miles after 8pm – the nearest being in Welling or at Gatwick airport.

We built the pharmacy with the intention of extending it so that we could provide enhanced services such as INR/warfarin testing, chiropody, asthma checks, blood pressure monitoring and diabetes testing. We also wanted to provide an NHS dentist on the premises but we're currently waiting for a decision from Medway Council on our planning application to extend the pharmacy. It was turned down in May because the council said I hadn't adequately justified the need for additional facilities from this location, even though 4,000 people signed a petition to say they wanted the services.

Meanwhile, I've had to put the enhanced services on hold while I re-submit the application. If I could provide these services I would be able to save patients the inconvenience of a trip to the hospital or having to wait for a doctor's appointment.

When we initially applied for the 100-hour licence with the PCT we had to wait for permission to be granted, which was an equally nerve-wracking experience, especially as we had taken a financial risk before the application was approved.

**How have the patients and GPs reacted?**
The patients greatly appreciate the out-of-hours services, particularly from eight to 11pm and on Sundays, when I can be very busy with EHC requests.

Overall, the GPs are happy and encourage us, particularly the Medway Doctors on Call and local hospitals since prior to us opening the pharmacy, pharmaceutical services weren't available for out-of-hours dispensing. The GPs themselves also use this service.

I've been awarded a Pride in Medway certificate in recognition of our outstanding contribution to the Medway community.

**Why do you think you have been successful?**
Because I am totally committed to my profession and want sincerely to help the community. My customers and patients have always rewarded me by making me feel as if I am a part of the community.

**Has offering the new service improved your job satisfaction?**
Yes. It has enabled me to interact more within the community and be accepted as a health professional.

## Under the white coat

**What are your hobbies when you're not at work?**
Listening to music, watching old movies and spending time with my family – especially now that I work 100 hours a week.

**If you were in charge of pharmacy for just one day, what would you change?**
I would devise a scheme in which pharmacists and doctors would interact more until they began to realise that their professions complement each other. We are both working together to improve the health and wellbeing of patients.

C+D

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From: **Hawkeye on the web**

Date: **Sat 21.07.07**

Subject: **Practice-Based Commissioning**

Pharmacists need to plan their attacks. It's less about hopefully asking for 'more' and more about putting together a slick presentation

There's something a bit Oliver Twist about pharmacy's role in practice-based commissioning. The common perception is one of the profession knocking on the GP's door with cap in hand asking politely for a slice of the PBC budget pie. And, if we're to believe some of the more negative rumblings on the subject, the doctors are likely to have enjoyed their fill already, leaving pharmacists with the leftovers.

One of the reasons for this view is that pharmacy feels its role in local healthcare provision is not being given due emphasis in PBC – and understandably so. The DH's PBC Early Wins and Top Tips document mentions pharmacy just once. http://tinyurl.com/2x38dw

The truth is, though, that PBC is a long way from being established and everything is up for grabs. The Department of Health's ultimate plan is to provide "a greater variety of services from a greater number of providers". Furthermore, it wants them to be provided in "settings that are closer to home and more convenient to patients". Sound familiar?

And, although power might be devolved, the PCTs still hold the budgets and will want to see the money used effectively. The question, then, is not whether pharmacy can deliver, it is whether the commissioners are aware of what pharmacy can deliver.

Pharmacists need to plan their attacks. It's less about hopefully asking for 'more' and more about putting together a slick presentation justifying your request for a share of the pie.

So far, 93 per cent of practices have taken up an incentive payment to get involved in PBC and the DH is aiming to get 100 per cent involvement by the year end. Pharmacy must act now to set out its stall for the future. Who are your commissioning practices and groups? Is your voice being heard on the PEC? Are you talking to local GPs about their plans?

To help you get involved, C+D has teamed up with the National Pharmacy Association to guide you through the issues around and implementation of PBC. From today, you can access a wealth of information from our online toolkit at www.dotpharmacy.com/PBC.

There will be articles from Stephen Fishwick of the NPA on the various aspects of commissioning that you should be considering. The first is on page 6 in this issue.

In addition, you can download guidelines on how to pitch your case to commissioners in the four key areas of COPD, falls, sexual health and obesity. These will be accompanied by commissioning templates that even outline the numbers you will need to crunch.

If you've got a question or would like to share your PBC experience with other pharmacists, you can email us at pbc@cmpmedica.com

The campaign will culminate with PBC Awareness Week between September 24 and 28. So log on and make sure you get your slice.

**Email** thawkins@cmpmedica.com

## ... what's new on the C+D website ... ...

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C+D News bulletin Click here

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2. NPA issues five-point guide to pseudoephedrine sales
3. Multiples second best for smoking services, survey finds
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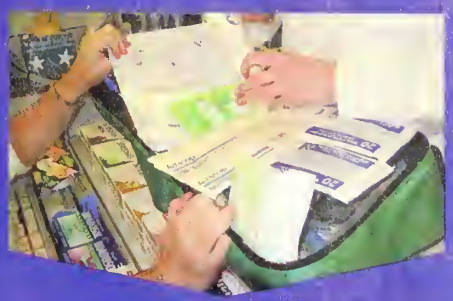

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